Prude v. Dixon, Case #23-cv-1233

Exhibit #1

Pages 1 of 19

DEPARTMENT OF CORRECTION
Division of Adult Institutions
Division of Juvenile Corrections
DOC-3035B (Rev. 2/2019)

[Exhibit #1] [1 of 19 Pages]

WISCONSIN

PSYCHOLOGICAL SERVICE REQUEST

- USE THIS FORM TO COMMUNICATE WITH THE PSYCHOLOGICAL SERVICES UNIT (PSU).
- USE THE BLUE DOC-3035 HEALTH SERVICE REQUEST IF YOUR REQUEST IS RELATED TO PSYCHIATRIC MEDICATION OR PSYCHIATRIC SERVICES
- PLACE ALL PAGES OF COMPLETED FORM IN THE DESIGNATED COLLECTION LOCATION.
- PRINT CLEARLY

LAST NAME	FIRST NAME	DOC NUMBER
Prude	Terrance	335478

FACILITY	HOUSING UNIT	CELL NUMBER	TODAY'S DATE
GBCI	RHU	423	3-15-23

REQUEST FOR:

- [X] PSYCHOLOGICAL SERVICES
- [ ] REQUEST FOR COPIES FROM PSU RECORD* (List records below)
- [ ] REQUEST FOR PSU RECORD REVIEW*
- [ ] INFORMATION
- [ ] OTHER:

*Youth aged 18 and over may request a file review and copies without parental consent. Youth under 18 years of age must obtain parental consent, by completing a DOC-1163A which can be obtained from the DOC, before requesting for a file review or copies.

FOLD THIS REQUEST OVER TO THE LINE BELOW SO THAT INFORMATION REMAINS CONFIDENTIAL

DO NOT USE THIS FORM IF YOUR MENTAL HEALTH NEED IS AN EMERGENCY, SPEAK TO STAFF DIRECTLY.
IN THE LINED AREA BELOW, WRITE DOWN WHAT YOUR REQUEST IS ABOUT. BE AS SPECIFIC AS YOU CAN.

I would like to speak to you again about my situation(being stabbed). I have been having dreams of the incident where I died from the stabbing. Also, I'm in pain from sleeping. I noticed that I cannot hold my head certain ways without it hurting. My entire neck is in pain.

[X] I WOULD LIKE TO SEE PSYCHOLOGY STAFF [ ] I DO NOT NEED TO SEE PSYCHOLOGY STAFF

DO NOT WRITE BELOW THIS LINE – TO BE FILLED IN BY STAFF ONLY

TRIAGED BY	DATE RECEIVED	ACTION	STAFF INITIALS
[X] PSU	3-16-23	[ ] Direct Response [X] Delegate to Ms. Woole	HKB
[ ] HSU		[ ] Refer to PSU (routine) [ ] Other (specify in notes below)	

NOTES (IF NEEDED)

RESPONSE

- [ ] A psychology appointment is scheduled for the following time frame: _____
- [ ] Your request has been referred to the Psychiatrist within the Health Service Unit
- [ ] Your request has been referred to the Health Services Unit for medical issues
- [ ] Refer for a record review appointment or for copies only. (Must be processed within 30 days of request)
- [X] Other: Absolutely. You're on my list to be seen. The stiffness + soreness is likely normal. If you feel swelling, a lot of heat or feverish. Or if infection comes out see HSU ASAP.

STAFF SIGNATURE	DATE SIGNED	PRINT STAFF NAME
A Woole PSU	3-17-23	

DISTRIBUTION: Original – Internal Paper Record PR Psychological Services Request

* Auth (Verified) *

[Exhibit#1] [2 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

⇦ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335678
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU	3-15-23 Wed

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE

DATE OF SERVICE

RECEIVED
MAR 16 2023

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☒ OTHER: Neck pain is traveling

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I have extreme neck pain in my neck and it has traveled from the left side of my neck to now being front, back and right side. I need to get some type of medical pillow and something to reduce/end the pain. Sleep bring the worst pain.

DATE RECEIVED: TO BE STAMPED BY HSU

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☒ Nursing Sick Call: ☒ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME: D. Henning RN

DATE OF HSU RESPONSE: 3/16/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

* Auth (Verified) *

[Exhibit#1] [3 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

⇦ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU-423	3-15-23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

RECEIVED MAR 16 2023

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

I'm in severe pain due to being stabbed in the neck. Is there a reason why I have not been prescribed pain med? I'm told I was taken off pain meds. Why? I told staff 3-15-23 (med staff) I was in pain I need pain med

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☒ Nursing Sick Call: ☒ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME D. Henning RN DATE OF HSU RESPONSE 3/16/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

* Auth (Verified) *

[Exhibit#1] [4 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU	3-16-23 Thursday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY
RECEIVED
MAR 17 2023
GBCI/HSU

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☒ OTHER: Special Needs Request

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

Again, I need some kind type of pillow 4 to sleep on. My neck injury & pains when I'm sleeping. The Doctor told me I'm experiencing nerve pain due to being stabbed in the neck. My neck needs some type of neck support structure while I'm sleeping.

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☒ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☒ Other: SNC extra pillow

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☒ Other:

COMMENT / INFORMATION

Ordered for 2 weeks.

PRINT STAFF NAME D. Henning RN DATE OF HSU RESPONSE 3/17/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

1 of 2 [Exhibit#1] [5 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU-423	3-19-23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

COPY

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Extreme Neck Pain

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

Why is my pain meds being continuously halted? I'm in severe neck pain. It feels like my neck is broken. Even small movements causes punishing pain in the neck. Why discontinue my pain meds knowing I need it?

I was stabled in the neck

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE -- TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

RECEIVED
MAR 20 2023
GBCI-HSU

☑ Nursing Sick Call: ☑ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

R. Matushak RN

PRINT STAFF NAME DATE OF HSU RESPONSE 3/20/23

DISTRIBUTION: Original -- Internal Paper Record, PR Patient Request Folder; Official Record -- Business Office File; Copies (2) -- Inmate Patient

2 of 2 [Exhibit#1] [6 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	B35878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU-423	3-19-23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Extreme Neck Pain

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

This pain is waking me up out of my sleep at night due to movements during sleep. The pain is most painful on the back & right sides of my neck & I must have some nerve damage as a result of being stabbed in my neck

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE -- TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☑ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only.

☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify):

☐ Other:

RECEIVED
MAR 20 2023
GBCI-HSU

COMMENT / INFORMATION

COPY

PRINT STAFF NAME R. Matushak RN DATE OF HSU RESPONSE 3/20/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[Exhibit#1] [7 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	HOUSING UNIT	TODAY'S DATE
GBCI	RHU-423	3-22-23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

RECEIVED
MAR 24 2023
GBCI-HSU

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

This pain in my neck has been going on for weeks. Instead of treating the pain why don't you investigate what's causing the pain? I've been in non-stop pain since being stabbed. The pain meds allow me to function but I want the pain to stop.

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

A referral to the MD is placed, not yet scheduled. Please indicate if you need to see nursing sooner.

PRINT STAFF NAME

K Baker

DATE OF HSU RESPONSE

3/24/2023

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

* Auth (Verified) *

[Exhibit #1] [8 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC 3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU-423	3-26-23

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

RECEIVED
MAR 27 2023
GBCI HSU

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☐ OTHER:

(3) **Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.**

DATE RECEIVED: TO BE STAMPED BY HSU

(1) When will HSU staff start investigating the reason why my neck is in severe pain? Also, why do HSU continue to stop my pain meds? Why does this keep happening? Also, why haven't I gotten the extra pillow ordered? (2)

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☒ Other:

COMMENT / INFORMATION

(1) Current order for Tylenol.
(2) Sgt Banke notified of same today 3/27.
(3) Provide referral in place, pending scheduling.

PRINT STAFF NAME D. Henning RN

DATE OF HSU RESPONSE 3/27/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

DEPARTMENT OF CORRECTION
Division of Adult Institutions
Division of Juvenile Corrections
DOC-3035B (Rev. 2/2019)

[Exhibit#1] [9 of 19 Pages]

WISCONSIN

PSYCHOLOGICAL SERVICE REQUEST

- USE THIS FORM TO COMMUNICATE WITH THE PSYCHOLOGICAL SERVICES UNIT (PSU).
- USE THE BLUE DOC-3035 HEALTH SERVICE REQUEST IF YOUR REQUEST IS RELATED TO PSYCHIATRIC MEDICATION OR PSYCHIATRIC SERVICES
- PLACE ALL PAGES OF COMPLETED FORM IN THE DESIGNATED COLLECTION LOCATION.
- PRINT CLEARLY

LAST NAME	FIRST NAME	DOC NUMBER
Prude	Terrance	335878

FACILITY	HOUSING UNIT	CELL NUMBER	TODAY'S DATE
GBCI	RHU	423	3-27-23

REQUEST FOR:

- [X] PSYCHOLOGICAL SERVICES
- [ ] REQUEST FOR PSU RECORD REVIEW*
- [ ] REQUEST FOR COPIES FROM PSU RECORD* (List records below)
- [ ] INFORMATION
- [ ] OTHER:

*Youth aged 18 and over may request a file review and copies without parental consent. Youth under 18 years of age must obtain parental consent, by completing a DOC-1163A which can be obtained from the DOC, before requesting for a file review or copies.

FOLD THIS REQUEST OVER TO THE LINE BELOW SO THAT INFORMATION REMAINS CONFIDENTIAL

DO NOT USE THIS FORM IF YOUR MENTAL HEALTH NEED IS AN EMERGENCY, SPEAK TO STAFF DIRECTLY.
IN THE LINED AREA BELOW, WRITE DOWN WHAT YOUR REQUEST IS ABOUT. BE AS SPECIFIC AS YOU CAN.

Today I woke up with my entire body sweating and when I opened my eyes I was seeing my fiet. I was dreaming about being stabbed again. That was a very trama motivated incident for me mentally & emotionally. How can I deal with this moving forward in this atmosphere? I really feel like someone is out to kill me due to all the circumstances. I've talked to my about.

- [X] I WOULD LIKE TO SEE PSYCHOLOGY STAFF
- [ ] I DO NOT NEED TO SEE PSYCHOLOGY STAFF

DO NOT WRITE BELOW THIS LINE – TO BE FILLED IN BY STAFF ONLY

TRIAGED BY	DATE RECEIVED	ACTION		STAFF INITIALS
[X] PSU	3-28-23	[ ] Direct Response	[X] Delegate to Ms. Woolf	HB
[ ] HSU		[ ] Refer to PSU (routine)	[ ] Other (specify in notes below)	

NOTES (IF NEEDED)

RESPONSE

- [ ] A psychology appointment is scheduled for the following time frame: _____
- [ ] Your request has been referred to the Psychiatrist within the Health Service Unit
- [ ] Your request has been referred to the Health Services Unit for medical issues
- [ ] Refer for a record review appointment or for copies only. (Must be processed within 30 days of request)
- [X] Other: I discussed your concerns w/ PSU Supervisor Dr. Hamilton and Sec. Dir Kind. Dr. Hamilton said he will discuss this plan w/ Kind to see about a red tag. I can't make guarantees as this is a security issue

STAFF SIGNATURE	DATE SIGNED	PRINT STAFF NAME
A Woolf PSW	3/28/23	

DISTRIBUTION: Original – Internal Paper Record PR Psychological Services Request

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-0643 (Rev. 8/2022)

Attempt To Resolve Issue

WISCONSIN

[Exhibit #1]
[10 of 19 Pages]

INTERVIEW/INFORMATION REQUEST
SOLICITUD PARA INFORMACION / ENTREVISTA

Instruction to Inmate: Do not use this form to contact health staff. Use a Health, Dental or Psychological Service Request.
Instrucciones para Reclusos: No utilice este formulario para comunicarse con el personal de cuidados de salud. Utilice una solicitud de servicio de cuidados de salud, dentales o psicológicos.

OFFENDER NAME / *NOMBRE DEL/LA OFENSOR(A)*	DOC NUMBER / *NUMERO DEL/LA OFENSOR(A)*	LIVING UNIT / *UNIDAD DE VIVIENDA*
Terrance Prude	[redacted]	RHU-423

DATE / *FECHA*	WORK ASSIGNMENT / *ASIGNACION DE TRABAJO*
3-27-23	

☐ Interview *Entrevista* ☒ Information *Informacion*

STATE REASON FOR INTERVIEW OR SPECIFY INFORMATION REQUESTED
INDICIQUE LA RAZON PARA LA ENTREVISTA O ESPECIFIQUE LA INFORMACION QUE SOLICITA

I've written so many HSR's since March 12, 2023 after being stabbed in my neck on 3-11-2023. The HSR's saying HSU staff to investigate why my neck is in so much pain has been ignored/remains not investigated. D. Markstaleh told me to go 2-3 weeks to see if the pain remains. Why should I have to wait that long just to have HSU staff [redacted] investigate why I'm in so much pain? I'm not even feeling the relief from the pain meds as I've told Markstaleh last week. I'm being treated with pain meds that is not working. What's next as far as treatment? How long will I have to wait?

(Do Not Write Below This Line) *(No Escriba Debajo Esta Linea)*

DISPOSITION OF REQUEST *DISPOSICION DE LA SOLICITUD*

RECEIVED
MAR 28 2023
GBCI-HSU

☐ You Will Be Interviewed
Usted sera entrevistado
Date: *Fecha:* Time: *Hora:*

☐ Information to Follow
Informacion Sera Proveida

☐ Request Referred To:
Solicitud Refereida A: Scheduled to see provider

Information/Comment:
Informacion/Comentario: for this 4/11/23. You currently have Tylenol available for pain. Let HSU know of any changes.

D. Henning RN
3/28/23

Signed *Firmado*

Department *Departamento*

* Auth (Verified) *

[Exhibit#1] [11 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN Administrative Code Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	RHU - 423	[redacted] - (3-27-23 Monday)

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

COPY

AUTHORIZED STAFF SIGNATURE

DATE OF SERVICE

RECEIVED MAR 2 8 2023

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

The pain meds are ineffective, I've been on them for 2 weeks and it was effective at first. But even with the pain meds I was still in modified pain. Now the meds does nothing. Why don't HSU medically investigate, what's the cause of the pain? How long does scheduling take?

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed:

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):
☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:
☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:
☐ Refer for copies only:
☐ Refer for Health Care Record review appointment
☐ Educational material attached (Specify):
☒ Other:

COMMENT / INFORMATION

You are scheduled to see the provider 4/11/23. If you need a RE sick call prior, let HSU know

PRINT STAFF NAME D. Henning RN

DATE OF HSU RESPONSE 3/28/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[Exhibit #1] [1 of 4] [12 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335678
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Treatment Center/321	3-30-23 Thursday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Need immediate, not delayed, medical treatment.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

My neck is in so much pain & so sore to where I cannot sleep. I also noticed that after being stabbed & having surgery (3-11-2023) I'm experiencing tremors in my face on the left side on my cheek bone area. It's a constant tremor. I believe being stabbed has caused me nerve damage. Also, my neck pain [redacted] feels [redacted] like it is

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

I moved your provider appointment to 4/7/23 which is the soonest I could do due to the providers schedule being full.

PRINT STAFF NAME J. Kilmer RN

DATE OF HSU RESPONSE 3/31/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

* Auth (Verified) *

[2 of 4] [Exhibit#1] [13 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Treatment Center/321	3-30-23 Thursday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Need immediate, not delayed, medical treatment.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

broken. It's hard to look up, down & sideways without extreme pain. The pain is most severe on the back of my neck & the sides. The pain meds are not effective anymore. I've never felt pain like this before. It's close to impossible to do sit ups of any type of exercises. I know I won't be able to play basketball anymore. Why do I have to wait until 4-11-2023 to see a provider?

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☒ Scheduled to be seen in HSU ☒ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

RECEIVED MAR 31 2023

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME J. Kilmer RN DATE OF HSU RESPONSE 3/31/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[3 of 4] [Exhibit#1] [14 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Treatment Center/Cell 321	3-30-23 Thursday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Need immediate, not delayed, medical treatment.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

I was stabbed & had surgery 3-11-23, why do I have to [redacted] wait till 4-11-23 to see a provider? This is a serious medical matter & I'm in extreme pain & the way my life has changed with being stabbed & the physical pain is depriving me of sleep & a physically healthy life. I'm not sure if you actually understand the pain I experience seeing no physical evaluations have been attempted at all. All I'm getting is

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

RECEIVED
MAR 31 2023
GBCI-HSU

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☒ Scheduled to be seen in HSU ☒ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME J. Kilmer RN DATE OF HSU RESPONSE 3/31/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[4 of 4] [Exhibit#1] [15 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

é NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335674
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Treatment Center/cell 321	3-30-23 Thursday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☒ OTHER: Need immediate, not delayed, medical treatment.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

responses (written) on these HSR's that keep saying you've issued pain meds (which I've already told you are no longer effective). My situation is urgent & making me wait over 2 weeks to be seen by a provider is indifferent to what I keep bringing to your attention. What am I supposed to do in the mean time with the untreated pain? Can you ~~please~~ schedule a meeting with provider earlier than 4-11-23?

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today): MAR 31 2023

☒ Scheduled to be seen in HSU ☒ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other: CBCI HSU

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

PRINT STAFF NAME: J. Kilmer RN

DATE OF HSU RESPONSE: 3/31/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[1 of 3] [Exhibit#1] [16 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Sch/E-63	4-11-2023 Tuesday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

COPY

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE

DATE OF SERVICE

RECEIVED
APR 13 2023
GBCI HSU

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☒ OTHER: Need immediate, not delayed, medical treatment

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

I'm in severe pain. The doctor ordered me two pain medication on 4-7-23 (Friday) and I still haven't gotten it yet. I'm deprived of sleep due to pain. I've been reporting this pain weekly. I'm being seen by HSU staff but the treatment ordered is not being provided & being delayed. I was stabbed in

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment

☐ Educational material attached (Specify): ☒ Other:

COMMENT / INFORMATION

Naproxen dispensed 4/11/23 for pain and you have been taking the muscle relaxer methocarbamol for pain since 4/11/23.

PRINT STAFF NAME
D. Henning RN

DATE OF HSU RESPONSE
4/13/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File, Copies (2) – Inmate Patient

[2 of 3] [Exhibit #1] [17 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC 3035 (Rev. 2/2019)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm. Code
Ch. DOC 316

⇦ NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	SCH/E-063	4/11/2023 Tuesday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

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- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

COPY RECEIVED APR 13 2023

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Need immediate, not delayed, medical treatment.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

my neck on 3-11-2023 and I've constantly reported being in severe pain. These long delays in being treated is causing me to be subject to unnecessary pain. The doctor told me the Naproxen & the methocarbamol would start on 4-11-2023 (Tuesday). I still haven't received the pain meds.

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☒ Other: see # 1 of 3

COMMENT / INFORMATION

PRINT STAFF NAME D. Henning RN DATE OF HSU RESPONSE 4/13/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

[3 of 3] [Exhibit #1] [18 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 2/2019)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm. Code
Ch. DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	SCH/E-63	4-11-2023 Tuesday

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE ▶

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

RECEIVED
APR 13 2023
GBCI/HSU

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Need immediate, not delayed, medical treatment

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

For the past 2-3 weeks I've been in pain daily & I keep reporting it. It took 2½ weeks just to get me to see a doctor and even after being ordered meds (by doctor) it has now been 5-days without any pain meds. I'm in severe pain and the delay is causing my pain to be unnecessary & unbearable.

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☒ Other: see p 1 of 3.

COMMENT / INFORMATION

PRINT STAFF NAME D. Henning RN DATE OF HSU RESPONSE 4/13/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

* Auth (Verified) *

[Exhibit#1] [19 of 19 Pages]

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2022)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Administrative Code
Chapter DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Prude	Terrance	335878
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	Sch/ E-63	4/19/2023

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

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- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

COPY

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE DATE OF SERVICE

RECEIVED
APR 20 2023

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☒ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☐ OTHER:

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

My neck re-injures when I go to sleep & wake up. My neck needs support when I'm sleeping. I'm not sure of why the Special Needs Committee denied me a neck support and a pillow. My neck is in constant pain every morning due to it not having support while I sleep.

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):
☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:
☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:
☐ Refer for copies only: ☐ Refer for Health Care Record review appointment
☐ Educational material attached (Specify): ☒ Other:

COMMENT / INFORMATION

You were just seen by the provider and have a follow up with the provider ordered.

Please continue to follow your plan of care

PRINT STAFF NAME

J. Kilmer RN

DATE OF HSU RESPONSE

4/20/23

DISTRIBUTION: Original – Internal Paper Record, PR Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient

Prude v. Dixon, Case #23-CV-1233

Exhibit #2

Pages 1 of 13

Hospital Sisters Health System

Prude, Terrance
MRN: 59332830, DOB: 4/29/1982, Sex: M

03/11/2023 - ED to Hosp-Admission (Discharged) in SVG 8 Surgical

Discharge Summary

Discharge Summary by Derrick J Ferry, APNP at 3/12/2023 1054

Discharge Summary
Trauma and Acute Care Surgery

Name: Terrance Prude
DOB: 4/29/1982
MRN: 59332830

Admit Date: 3/11/2023

Discharge Date: 3/12/2023

Admitting Provider: Maymoona A Attiyat, MD

Discharging Provider: Maymoona Attiyat, MD

Primary Care Provider: No primary care provider on file.

Reason for Admission:
Stab wound of neck

Discharge Diagnosis / Plan:
Stab wound of neck

Surgeries/Procedures:
Procedures: esophogram, intraop bronchoscopy - both negative for injury
Surgery: neck wound exploration with removal of foreign body, control of bleeding

Consultations:
None

History of Present Illness:
Terrance Prude is a(n) 40-year-old male currently incarcerated reportedly was assaulted with a plastic object which penetrated the left side of his neck. Bleeding is controlled on arrival. The patient denied any nausea or vomiting, no dizziness apnea, no dysphagia or odynophagia.

Hospital Course:
Patient proceeded to the operating room for local wound exploration and removal of plastic foreign body. During the procedure he also underwent bronchoscopy which showed no evidence of bronchial injury. Following surgery he also underwent esophagram which also showed no evidence of penetrating injury. Patient is admitted to the hospital for supportive cares and monitoring. The following day patient denied any difficulty swallowing was able to tolerate a general diet. Pain was controlled with oral analgesics. No new injuries on tertiary exam. This time he stable for discharge.

Follow-up Appointment(s):
Trauma Clinic as needed

[Exhibit#2] [1 of 13 Pages]

Hospital Sisters Health System

Prude, Terrance
MRN: 59332830, DOB: 4/29/1982, Sex: M

03/11/2023 - ED to Hosp-Admission (Discharged) in SVG 8 Surgical (continued)

Discharge Summary (continued)

Discharge Instructions:

Anticoagulation: N/A
Antibiotics: Perioperative
Pain Control: Trauma pain meds: Acetaminophen, NSAID and Ice / Heat
Activity: Activity as tolerated
Diet: No restrictions
Wound/drain care: Keep dressing in place for 24 more hours then remove reapply as needed, monitor for s/sx of infection

Home medication changes: N/A

Disposition:
At this time, patient is deemed appropriate for discharge to **Home (General Discharge)**. A detailed discussion was had about the discharge process with the patient regarding follow-up appointments, pain management, activity restrictions, wound care, and/or signs and symptoms for which the patient should call or go directly to the closest emergency department for. All questions are answered.

Physical Examination at Time of Discharge:
Please refer to the progress note from date of discharge.

Medications at Time of Discharge:

Current Discharge Medication List

START taking these medications

	Details
acetaminophen (TYLENOL) 325 MG tablet	Take 2 tablets (650 mg total) by mouth every 6 (six) hours as needed for Pain. *Qty:* 30 tablet, *Refills:* 0

Please note greater than 35 minutes was spent in all aspects of the discharge process time with majority occuring at bedside and in Epic chart review.

Thank you,
Derrick J Ferry, APNP
Trauma and Acute Care Surgery
3/12/2023

Prevea Health
835 S Van Buren St
Green Bay, WI 54301
Office (920) 436-1358 (8:00 am-5:00 pm)
Contact after hours nurse triage (920) 496-4700 before 8:00 am or after 5:00 pm
Fax (920) 431-3169

Electronically signed by Derrick J Ferry, APNP at 03/12/23 1108
Electronically signed by Maymoona A Aliyat, MD at 03/12/23 1754

[Exhibit #2] [2 of 13 Pages]

Hospital Sisters Health System

Prude, Terrance
MRN: 59332830, DOB: 4/29/1982, Sex: M

03/11/2023 - ED to Hosp-Admission (Discharged) in SVG 8 Surgical (continued)

Discharge Summary (continued)

[Exhibit#2] [3 of 13 Pages]

Progress Notes

Document Type: Nursing Narrative Note
Service Date/Time: 3/12/2023 10:13 CDT
Result Status: Modified
Document Subject: Hospital Update
Sign Information: Baker,RN,Ellyn M (3/12/2023 12:43 CDT); Baker,RN,Ellyn M (3/12/2023 10:19 CDT)

Addendum by Baker, RN, Ellyn M on March 12, 2023 12:43 CDT
1205pm. Bethany RN called report for patient who is being discharged today. Tylenol order will be sent in hardcopy. Pt last Tylenol dose 8 am today.
Pt has gauze and transparent dressing covering wound. No wound care orders given.
Security called to inform. Talked to Mejia about this discharge.

Electronically Signed on 03/12/23 12:43 PM

Baker, Ellyn RN

Bethany RN report: Foreign object successfully removed. Pt still having a lot of pain.
Swallow study preformed today - all is good. Currently waiting on provider orders to discharge today or tomorrow.

Electronically Signed on 03/12/23 10:19 AM

Baker, Ellyn RN

Document Type: Nursing Narrative Note
Service Date/Time: 3/11/2023 13:45 CST
Result Status: Auth (Verified)
Document Subject: Sick call Cold symptoms - seen for foriegn object to neck
Sign Information: Baker,RN,Ellyn M (3/11/2023 13:50 CST)

Pt ambulated to HSU with 2 escorts with an even steady pace. Pt was stabbed in the neck with a foreign object. Object protruding out of right side of the neck bleeding slowly. RN determined Ambulance to be called for an evaluation at the ED. Pt never lost consciousness. He was A&O x4. Security treated his OC sprayed eyes while the RN assessed the wound. Pt whisked away to prepare for transport. RN continued to monitor patient.
Pt asked why he was called to HSU. RN stated cold symptoms. Pt stated he never wrote the HSR.
Ambulance took pt to St. Vincent Hospital. RN called report.

Electronically Signed on 03/11/23 01:50 PM

Baker, Ellyn RN

Document Type: Progress Note Generic
Service Date/Time: 4/7/2023 11:00 CDT
Result Status: Auth (Verified)
Document Subject: Phone Call from sister
Sign Information: Merbach,MPAA,Lisa A (4/7/2023 11:05 CDT)

[Exhibit #a] [4 of 13 Pages]

Progress Notes

Writer received a phone call from Swera Faraj wanting to discuss Prude, T medical file.
I informed her we di not have a 1163A on file for me to speak with her.
Sent DOC 1163A to Mr Prude for him to fill out if he would ike us to speak with her.

Electronically Signed on 04/07/23 11:05 AM

Merbach, Lisa MPAA

Document Type:	Progress Note Generic
Service Date/Time:	3/14/2023 09:49 CDT
Result Status:	Auth (Verified)
Document Subject:	Neck injury, asthma
Sign Information:	Daughtry,MD,Barry T (3/14/2023 09:57 CDT)

Subjective
He is being seen for a stab wound in the neck. He was stabbed with a pen and the foreign body was extracted in the emergency room. He has self absorbing sutures in the left neck. Complains of neck pain when he sleeps. He has tylenol for pain.
He has asthma which is well controlled.

Objective

Vitals & Measurements
Temperature Temporal Artery: 37.1 Deg C (03/14/23 09:46:00)
Peripheral Pulse Rate: 73 bpm (03/14/23 09:46:00)
Respiratory Rate: 14 br/min (03/14/23 09:46:00)
Systolic Blood Pressure: 125 mmHg (03/14/23 09:46:00)
Diastolic Blood Pressure: 67 mmHg (03/14/23 09:46:00)
Mean Arterial Pressure, Cuff: 86 mmHg (03/14/23 09:46:00)

Physical Exam
Neck: healed laceration left neck about 6-7 cm long with some swelling, no lymphadenopathy or erythema
Oropharynx: benign
General: Alert, no acute distress
Lungs: Clear to auscultation
Heart: Regular rate, rhythm, no murmurs, rubs or gallops
Extremities: No edema

Assessment/Plan
1. Puncture wound of neck with foreign body
Healing, reassurance

2. Asthma
continue inhalers
follow up in 2 months

Antisocial personality disorder

Bilateral plantar fasciitis

Encounter for laboratory testing for COVID-19 virus

Encounter for medical care
Ordered:

[Exhibit#a] [5 of 13 Pages]

Progress Notes

acetaminophen, 650 mg = 2 tab, Oral, Tab, QID - SC for 3 days, PRN pain, First Dose: 03/12/23 14:03:00 CDT, Stop Date: 03/15/23 14:02:00 CDT, Next Dispense Date: 03/13/23

Focal hyperhidrosis

Insomnia

Pain in right shoulder

Seasonal asthma

Shoulder pain

Electronically Signed on 03/14/23 09:57 AM

Daughtry, Barry MD

[Exhibit#2] [6 of 13 Pages]

Progress Notes

Document Type: Nursing Narrative Note
Service Date/Time: 3/16/2023 11:00 CDT
Result Status: Auth (Verified)
Document Subject: Neck pain from stabbing
Sign Information: Reindl,RN,Steven (3/16/2023 11:06 CDT)

S-"I had Tylenol ordered and that was helping with the pain but then it stopped yesterday, I have used IBU in the past and it worked better"
O-pt ambulated to HSU with an even steady gait in no acute distress. Pt has full ROM of head with slight discomfort. Wound L-side neck intact healing with no S/S of infection.
A-Pain AEB pt statement
P-IBU ordered per RN protocol. Pt wil update HSU with any changes or worsening symptoms.

Electronically Signed on 03/16/23 11:06 AM

Reindl, Steven RN

Document Type: Nursing Narrative Note
Service Date/Time: 3/12/2023 15:02 CDT
Result Status: Auth (Verified)
Document Subject: Hospital to RHU move
Sign Information: Potapenko,LPN,Amy L (3/12/2023 15:03 CDT)

Patient back from the hospital and moved to RHU.

The following medications were placed in the RHU bucket to be brought up to RHU:

Acetaminophen 325mg-12 tabs (nursing protocol order)
Albuterol Inhaler-1 inhaler
Cetirizine 10mg-30 tabs
Alvesco 80mcg-1 inhaler

Electronically Signed on 03/12/23 03:03 PM

Potapenko, Amy LPN

Document Type: Nursing Narrative Note
Service Date/Time: 3/12/2023 13:52 CDT
Result Status: Modified
Document Subject: Hospital Return assessment
Sign Information: Baker,RN,Ellyn M (3/12/2023 14:17 CDT); Baker,RN,Ellyn M (3/12/2023 14:03 CDT)

[Exhibit#a] [7 of 13 Pages]

Progress Notes

P) Discussed organ donation policy #500.30.13. Informed I would submit referral to discuss both items with MD. Mr. Prude versed understanding and appreciative.

Electronically Signed on 04/13/23 04:27 PM

Garland, Shane RN

Document Type:	Nursing Narrative Note
Service Date/Time:	4/11/2023 11:12 CDT
Result Status:	Auth (Verified)
Document Subject:	Phone call
Sign Information:	Kilmer,RN,Jennifer L (4/11/2023 11:13 CDT)

Received a phone call from CO Rhome in the SCH that the patient is having neck pain. This is not new for the patient and the patient just saw the ACP for this. I advised the patient write an HSR.

Electronically Signed on 04/11/23 11:13 AM

Kilmer, Jennifer RN

Document Type:	Nursing Narrative Note
Service Date/Time:	3/20/2023 11:07 CDT
Result Status:	Auth (Verified)
Document Subject:	Sick call Neck pain
Sign Information:	Matushak,RN,Rachel M (3/20/2023 11:16 CDT)

Patient ambulates to HSU with steady even gait in no acute distress. Patient states that he does not need to be seen that he just needs a long term order for Tylenol. ACP Daughtry contacted. Tylenol ordered for 90 days per ACP. Patient thankful and voiced no other concerns for HSU. Follow up PRN.

Electronically Signed on 03/20/23 11:16 AM

Matushak, Rachel RN

[Exhibit #2] [8 of 13 Pages]

Progress Notes

Document Type:	Nursing Narrative Note
Service Date/Time:	4/13/2023 11:53 CDT
Result Status:	Modified
Document Subject:	Cell Search
Sign Information:	Potapenko,LPN,Amy L (4/19/2023 16:40 CDT); Potapenko, LPN,Amy L (4/14/2023 14:43 CDT); Potapenko,LPN,Amy L (4/13/2023 11:55 CDT)

Addendum by Potapenko, LPN, Amy L on April 19, 2023 16:40 CDT
Charge RN went to patients cell to issue a stock card of naproxen on 4/14/23. Patient showed the RN that he has a card of Naproxen already in cell.

Electronically Signed on 04/19/23 04:40 PM

Potapenko, Amy LPN

Addendum by Potapenko, LPN, Amy L on April 14, 2023 14:43 CDT
PC to the SCH to see if the cell search for this patient was conducted. The SCH cage officer cannot confirm if a cell search ws done or not done on this patient. Writer asked for a cell search to be conducted to ensure if patient does or does not have his medication. If cell search is conducted and no Naproxen is found a stock card will have to be issued.

Electronically Signed on 04/14/23 02:43 PM

Potapenko, Amy LPN

Reviewed by: Garland, RN, Shane C

Per patient he does not have his Naproxen 500mg that was checked out of the medication room on 4/11/23. Per MAR medication was not scanned to patient. Writer called the SCH to have a cell search to make sure there was no card of Naproxen in cell before more Naproxen will be issued.

Electronically Signed on 04/13/23 11:55 AM

Potapenko, Amy LPN

Reviewed by: Kilmer, RN, Jennifer L

Document Type:	Nursing Narrative Note
Service Date/Time:	4/13/2023 09:45 CDT
Result Status:	Auth (Verified)
Document Subject:	Organ donation inquiry
Sign Information:	Garland,RN,Shane C (4/13/2023 16:27 CDT)

S) States he wanted to figure out if he could be a match to donate a kidney to a family member. Also concerned with continued neck pain s/p assault. States current medication is not working.
O) Ambulates to HSU with steady gait and in no acute distress.
A) Informational

[Exhibit#2] [9 of 13 Pages]

Current Medications list

Inpatient

Order: **mirtazapine**
Ordering Physician: Rojas,MD,Alexis A
Order Details: 15 mg = 1 tab, Oral, Tab, HS - SC for 350 days, First Dose: 4/18/23 8:00:00 PM CDT, Stop Date: 4/2/24 7:59:00 PM CDT, Next Dispense Date: 08-MAY-2023 09:00:00.00
Order Comment:

Order: **bacitracin topical (bacitracin 500 units/g topical ointment)**
Ordering Physician: Daughtry,MD,Barry T
Order Details: 1 app, Topical, Form: Ointment, Daily - KOP for 30 days, First Dose: 4/7/23 11:51:00 AM CDT, Stop Date: 5/7/23 11:50:00 AM CDT, Next Dispense Date: 04/07/26
Order Comment:

Order: **naproxen**
Ordering Physician: Daughtry,MD,Barry T
Order Details: 500 mg = 1 tab, Oral, Tab, BID (AM/PM) - KOP for 90 days, PRN pain, First Dose: 4/11/23 7:30:00 AM CDT, Stop Date: 7/10/23 7:29:00 AM CDT, Next Dispense Date: 01-MAY-2023 09:00:00.00
Order Comment:

Order: **methocarbamol**
Ordering Physician: Daughtry,MD,Barry T
Order Details: 750 mg = 1 tab, Oral, Tab, HS - SC for 3 weeks, PRN muscle spasm, First Dose: 4/11/23 8:00:00 PM CDT, Stop Date: 5/2/23 7:59:00 PM CDT, Next Dispense Date: 07-APR-2026 09:00:00.00
Order Comment:

Order: **acetaminophen (acetaminophen 325 mg oral tablet range dose)**
Ordering Physician: Daughtry,MD,Barry T
Order Details: 1 to 2 Tablets, Oral, QID - KOP for 90 days, PRN pain, First Dose: 3/20/23 9:01:00 AM CDT, Stop Date: 6/18/23 7:29:00 AM CDT, Form: Tab, Next Dispense Date: 29-MAR-2023 09:00:00.00
Order Comment:

[Exhibit#a] [10 of 13 Pages]

Orders

Pharmacy

Order: mirtazapine

Order Date/Time: 4/13/2023 14:11 CDT

Order Status: Ordered | Department Status: Ordered

End-state Date/Time: 4/2/2024 19:59 CDT | End-state Reason:

Ordering Physician: Rojas,MD,Alexis A | Consulting Physician:

Entered By: Rojas,MD,Alexis A on 4/13/2023 14:11 CDT

Order Details: 15 mg = 1 tab, Oral, Tab, HS - SC for 350 days, First Dose: 4/18/23 8:00:00 PM CDT, Stop Date: 4/2/24 7:59:00 PM CDT, Next Dispense Date: 08-MAY-2023 09:00:00.00

Action Type: Modify	Action Date/Time: 4/14/2023 14:55 CDT	Electronically Signed By: Schoofs,RPh, Roberta S

Communication Type: Written

Action Type: Order	Action Date/Time: 4/13/2023 14:11 CDT	Electronically Signed By: Rojas,MD, Alexis A

Communication Type: Written

Order: bacitracin topical (bacitracin 500 units/g topical ointment)

Order Date/Time: 4/7/2023 11:51 CDT

Order Status: Ordered | Department Status: Ordered

End-state Date/Time: 5/7/2023 11:50 CDT | End-state Reason:

Ordering Physician: Daughtry,MD,Barry T | Consulting Physician:

Entered By: Daughtry,MD,Barry T on 4/7/2023 11:51 CDT

Order Details: 1 app, Topical, Form: Ointment, Daily - KOP for 30 days, First Dose: 4/7/23 11:51:00 AM CDT, Stop Date: 5/7/23 11:50:00 AM CDT, Next Dispense Date: 04/07/26

Action Type: Modify	Action Date/Time: 4/7/2023 11:56 CDT	Electronically Signed By: Heberlein, RPh,Gregory W

Communication Type: Written

Action Type: Order	Action Date/Time: 4/7/2023 11:51 CDT	Electronically Signed By: Daughtry,MD, Barry T

Communication Type: Written

Order: naproxen

Order Date/Time: 4/7/2023 11:48 CDT

Order Status: Ordered | Department Status: Ordered

End-state Date/Time: 7/10/2023 07:29 CDT | End-state Reason:

Ordering Physician: Daughtry,MD,Barry T | Consulting Physician:

Entered By: Daughtry,MD,Barry T on 4/7/2023 11:48 CDT

Order Details: 500 mg = 1 tab, Oral, Tab, BID (AM/PM) - KOP for 90 days, PRN pain, First Dose: 4/11/23 7:30:00 AM CDT, Stop Date: 7/10/23 7:29:00 AM CDT, Next Dispense Date: 01-MAY-2023 09:00:00.00

Action Type: Order	Action Date/Time: 4/7/2023 11:48 CDT	Electronically Signed By: Daughtry,MD, Barry T

Communication Type: Written

Psychiatric

DOCUMENT NAME:	Psychiatric Progress Note
SERVICE DATE/TIME:	4/13/2023 14:05 CDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Rojas,MD,Alexis A (4/13/2023 14:05 CDT)
SIGN INFORMATION:	Rojas,MD,Alexis A (4/13/2023 14:13 CDT)

Telepsychiatry Follow-Up

Subjective/Interval History:
Patient currently in general population. I have reviewed prior PSU and psychiatrist notes. Patient has consented to use of secure video conferencing. Patient is aware of the limits of confidentiality. last visit was January 2023; he wasn't on psych meds and follow up was as needed. says he was stabbed in the neck 3/11/23 by another inmate. says he has nerve damage and required surgery. since then has had nightmares and insomnia. has been hypervigilant around others since the trauma. is interested in restarting mirtazapine which was helpful in the past.

Per most recent PSU clinician note:
Diagnoses:
"Antisocial personality disorder
Insomnia

Med Trials per patient: mirtazapine 15 mg po qhs (effective)
Med Trials per chart:
SA: none per patient.
Medical Dx Hx: shoulder injury per patient, asthma.

Current Medications:
Medications (7) Active
Scheduled: (3)
Bacitracin Topical Oint (TUBE) 1 app, Topical, Daily - KOP
Cetirizine 10 mg Tab 30 (BTL) 10 mg 1 tab, Oral, Daily - KOP
Ciclesonide 80 mcg/inh 6.1 g (INHALER) 80 mcg 1 puff(s), Inhalation, BID (AM/HS) - KOP
Continuous: (0)
PRN: (4)
Acetaminophen 325 mg Tab 1 to 2 Tablets, Oral, QID - KOP
Albuterol HFA 90 mcg/inh 18gm (INHALER) (66993-0019-68) 180 mcg 2 puff(s), Inhalation, QID - KOP
Methocarbamol 750 mg Tab 750 mg 1 tab, Oral, HS - SC
Naproxen 500 mg Tab 500 mg 1 tab, Oral, BID (AM/PM) - KOP

Active Allergies (1)
No Known Medication Allergies
Reaction: None Documented

Mental Status Exam:
Fair grooming. Wearing prison issued clothing. Speech is normal volume, rate and tone. Mood is "ok". Affect is euthymic. Thought process linear and logical. Denies ah and vh. Denies si and hi. Insight is fair. Judgment is fair. Cognition grossly intact.

Impression:
Patient expressed an understanding of the risks, benefits, and alternatives to the treatment plan and consents to the plan. Patient has capacity to consent at this time. Patient vouching for his safety and states he will inform staff if suicidal. Patient appears to be attending to his ADLs with no evidence of grave disability secondary to a psychiatric condition.

Risk Assessment: Risk Elevation From Baseline: Minimal. Baseline: Low.
-Risk Factors: existing psych diagnosis.
-Protective Factors: No organized plan, No current substance misuse, Not intoxicated, Future oriented and hopeful, Intact thought process, no past attempt, No life threatening illness.

[Exhibit#2] [12 of 13 Pages]

Psychiatric

DSM 5 Diagnoses:
Antisocial personality disorder
Acute stress disorder. (trauma was on 3/11/23)

Plan:
- Start mirtazapine 15 mg po qhs for anxiety and insomnia.
- Continue routine follow up with PSU.

RTC: 6 weeks.

Electronically Signed on 04/13/23 02:13 PM

Rojas, Alexis MD

[Exhibit#2] [13 of 13 Pages]

Prude v. Dixon, Case #23-CV-1233

Exhibit #3

Pages 1 of 4

Consultations

Document Type:	Inpatient PT Evaluation
Service Date/Time:	12/22/2023 12:46 CST
Result Status:	Auth (Verified)
Document Subject:	Inpatient PT Evaluation
Sign Information:	Bothfeld,PT,Nathaniel S (12/22/2023 15:58 CST)

Inpatient PT Evaluation Entered On: 12/22/2023 12:51 CST
Performed On: 12/22/2023 12:46 CST by Bothfeld, PT, Nathaniel S

General Info
Pain Present : Yes actual or suspected pain
PT General Information Subjective History : SUBJECTIVE:
Per pt report/EMR/WICS Conduct Report; pt was stabbed with a pen by another PIOC on 3/11/23 while in GBCI HSU; the pen went into the neck, left/lateral to the trachea/esophagus and broke off; neck pain sx have improved vastly since then but still a 2/10 PR on average and a 4/10 PR at worst; he is currently on AC; he works out in the cell performing frog hops, burpees, push ups, tyson push ups and sit ups and crunches; he takes Naproxen for pain management

OBJECTIVE:
Gait is normal. Transfers are normal. Pt rear cuffed and escorted by CO on RHU. Cervical AROM is WFL in all planes. Scar present left of the throat present. Forward head posture observed. Verbally instructed pt on HEP: form, parameters and rationale and deep cervical flexor mm strength and endurance normative values.

Bothfeld, PT, Nathaniel S - 12/22/2023 15:58 CST

Orientation : Oriented x 4
Affect/Behavior : Appropriate, Calm, Cooperative
Safety/Judgment : Able to find way around unit
Basic Command Following : Intact

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Pain Assessment
Pain Location : Neck
Laterality : Bilateral
Quality : Aching
Time Pattern : Intermittent
Onset : Gradual
Self Report Pain : Numeric rating scale
Numeric Pain Scale : 4
Acceptable Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 4
Numeric Pain Acceptable Intensity Score : 0

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Mobility
Mobility Grid
Roll Left : Complete independence
Roll Right : Complete independence
Supine to Sit : Complete independence

[Exhibit#3] [1 of 4 Pages]

Consultations

Sit to Supine : Complete independence
Scooting : Complete independence
Transfer Sit to Stand : Complete independence
Transfer Stand to Sit : Complete independence
Transfer Bed to and From Chair : Complete independence
Transfer Toilet : Complete independence

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Ambulation Level : Complete independence
Stairs : Does not occur

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Assessment
PT Impairments or Limitations : Muscle weakness, Myofascial pain
Treatment Recommendations : 41 yo male reporting chronic anterior and posterior neck pain 9 months s/p being stabbed in the left anterior neck by a pen during an assault that occurred while in GBCI HSU. AROM of the cervical spine is full in all planes and pt is I with all ADLs and is able to perform his normal calisthenics/exercise regimen but pt still reporting mild neck pain and stiffness that rates from 2-4/10 PR in severity. Pt was instructed on PT HEP: form, parameters and rationale and we discussed POC and pt agrees to adhere to the PT HEP. HEP dispensed to pt's unit and PT f/u scheduled for in 2 weeks.

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Education
Teaching Method : Demonstration, Explanation, Printed materials, Teach-back

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Physical Therapy Education Grid
Exercise Program : Verbalizes understanding, Demonstrates
Physical Therapy Plan of Care : Verbalizes understanding

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Long Term Goals
PT Patient,Caregiver Goal : "Not have neck pain anymore."

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PT Long Term Goals Grid

	Long Term Goal 1
Goal :	SEE STGs
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PT Short Term Goals
Other PT Goals Grid

	Goal #1	Goal #2	Goal #3
Goal :	Perform HEP, I	Adhere to PT HEP, 3-5x/week for 12 weeks	Demonstrate full and normal deep cervical flexor mm strength and endurance, assessed via Chin Tuck, Head Lift Test, 1-3'
Status :	Progressing, continue	Progressing, continue	Progressing, continue

[Exhibit #3] [2 of 4 Pages]

Consultations

	Bothfeld, PT, Nathaniel S - 12/22/2023 15:58 CST	Bothfeld, PT, Nathaniel S - 12/22/2023 15:58 CST	Bothfeld, PT, Nathaniel S - 12/22/2023 15:58 CST

Plan
Frequency : 2 times per month
Duration : 12 Weeks
Treatments Planned : Electric modalities, Pain management, Patient education, Therapeutic exercises
Treatment Plan/Goals Established With Patient/Caregiver : Yes
Other PT Treatment Provided : Composed and instructed pt on initial HEP; form, parameters and rationale.
Evaluation Complete : Yes

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Time Spent With Patient PT
PT Evaluation units moderate : 3 units

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Additional Information
Additional Information PT : Dx: Chronic Neck Pain, DOI/MOI: 3/11/2023 via Stab Wound Left of Throat with a Pen in GBCI HSU

HEP:
-Cervical Retraction, 10 x 10 x 2-5 second hold/daily
-Prone Y, T, I, 3-5 x 10-20 reps, hold for 5-10 second hold, 2-3 days/week
-Supine Cervical Self Applied Traction, PRN, 1-3 x 1-3'
-Supine Chin Tuck, Head Lift, 3-5 x 1', 2-3 days/week
-AROM of Cervical Spine: 10 x 10 reps/daily, in all planes
-Cued pt to maintain cervical retraction during his calisthenic regimen

Bothfeld, PT, Nathaniel S - 12/22/2023 15:58 CST

[Exhibit#3] [3 of 4 Pages]

State of Wisconsin
Department of Corrections

Patient Information

MRN: 000335878

Name:	**PRUDE, TERRANCE D**	FIN:	**200102160101335878**
Location:	**WSPF _AR1**	Admit Date:	**02/16/01**
Room:	**_111 _L**	Attending MD:	**Degiovanni, MD, Gina**
Date of Birth:	**04/29/82**	E-Signed By:	**Degiovanni, MD, Gina**
Age:	**41 Years**	LOS:	**8386 Days**
Sex:	**Male**		
Height:			
Weight:			

Admitting Diagnosis:
Allergies: **No Known Medication Allergies**

Ordering Information

Order Action: **Order**

Order: **TENS UNIT**

Requested Start Date/Time:	01/05/23 15:03:00 CST
Duration:	90
Duration Unit:	days
Stop Date/Time:	04/05/23 16:02:00 CDT
Patient's Location -- Facility:	WSPF
Special instructions:	TENS Unit. Chronic Posterior Neck Pain. 90 days. 1 unit, 2 leads, 4 electrodes, 1 9V battery, all present and working. Dispensed on 1/5/2024.

Order ID: 1439968641

Comments:

Ordered By: Bothfeld, PT, Nathaniel S

Order Date/Time: 02/01/24 CST
Communication Type: Written

[Exhibit #3]
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